No. 06-923

IN THE

Supreme Court of the United States

METLIFE (METROPOLITAN LIFE INSURANCE COMPANY) AND LONG TERM DISABILITY PLAN FOR ASSOCIATES OF SEARS, ROEBUCK AND COMPANY,

Petitioners,

– v. –

WANDA GLENN,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF FOR RESPONDENT

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QUESTIONS PRESENTED

Petitioner MetLife is a dual-role ERISA plan fiduciary, which means that it both decides whether beneficiaries are eligible for benefits and pays any benefits it grants out of its own pocket. The Court of Appeals found MetLife's denial of an employee's disability claim arbitrary and capricious in multiple respects. The questions presented are:

1. Was the Court of Appeals correct in concluding that MetLife's dual-role status is a conflict of interest that a court must consider in reviewing MetLife's benefit denial?

2. If a dual-role insurer is deemed to be operating under a conflict of interest, how should that conflict be taken into account in judicial review of a discretionary benefit decision?

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STATEMENT OF THE CASE

Petitioner Wanda Glenn maintained an impeccable work record at Sears, Roebuck, and Company ("Sears") for 14 years, when a potentially fatal heart disease cut her career short. P.A. 2a, 46a.[1] Ms. Glenn, now 55, turned to MetLife to pay the benefits she had been promised under Sears's long-term disability plan, an employee welfare benefit plan governed by ERISA. P.A. 3a.

The Court of Appeals found MetLife's denial arbitrary and capricious in multiple respects, noting that MetLife systematically and inexplicably ignored critical evidence, reversed positions, and rejected the consistent opinion of an examining cardiologist in favor of consultants who reviewed a cold paper record. P.A. 10a–25a. In the course of its opinion, the Court of Appeals took note of the fact that MetLife is a dual-role insurer, which means that it both (1) decides whether to pay benefits and (2) pays any benefits it grants out of its own pocket. P.A. 10a. In so doing, the Court of Appeals was following this Court's direction in *Firestone Tire & Rubber v. Bruch*, that such a dual-role "conflict *must* be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. 101, 115 (1989) (quoting RESTATEMENT

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[1] The Petition is cited as "Pet." and the Appendix to the Petition is cited as "P.A." Petitioners' merits brief is cited as "Pet'r," and the Joint Appendix as "J.A." The Administrative Record in the District Court is cited as "A.R." Amicus briefs are cited as "_____ Br.," according to the abbreviation or shortened name of the lead amicus.

(SECOND) OF TRUSTS § 187, cmt. d (1959) ("SECOND RESTATEMENT") (emphasis added)).

MetLife insists that the ruling must be vacated because the Court of Appeals *must not* even consider that dual-role conflict of interest in reviewing the benefit denial. MetLife's position is inconsistent with this Court's precedent, trust law, ERISA's purposes, and common sense.

Ms. Glenn Is Disabled by a Severe Heart Condition

The disease that ended Ms. Glenn's career has plagued her for more than 25 years. It began with hypertension, in the early 1980s. P.A. 4a. Then, in 1989, Ms. Glenn suffered a near-death experience called "sudden cardiac death." *Id.* Doctors implanted a defibrillator in Ms. Glenn's chest to keep her alive, but her condition deteriorated over time. *Id.*

Doctors diagnosed Ms. Glenn with left ventricular dysfunction, *id.*, and then eventually with severe dilated cardiomyopathy, a disease that interferes with the heart's ability to pump blood, P.A. 3a. Ms. Glenn suffered prolonged chest tightness, shortness of breath, and "increasing fatigue" throughout the day. P.A. 4a; J.A. 82.

By the spring of 2000, Ms. Glenn's treating cardiologist, Dr. Rajendra Patel, concluded that Ms. Glenn had to leave Sears to preserve her health. P.A. 4a–5a. The "physical as well as psychologic stress" from her job as a manager, he concluded, was literally deteriorating her heart. J.A. 82. In April 2000, Dr. Patel opined, "From my standpoint, this patient cannot return to any kind of job that would require any significant physical or

psychological stress." J.A. 88. A cardiovascular disease specialist at Ohio State University confirmed the diagnosis. P.A. 43a. Acceding to doctors' orders, Ms. Glenn took medical leave. P.A. 4a–5a.

MetLife Helps Persuade the Social Security Administration Ms. Glenn Is Disabled

Ms. Glenn submitted a long-term disability claim to MetLife. P.A. 3a. MetLife was contractually bound to pay disability benefits for the first two years if Ms. Glenn could not "completely and continuously ... perform each of the material duties of [her] regular job" as a sales manager. *Id.* (alteration in original). MetLife concluded that Ms. Glenn was "totally disabled" within the meaning of the plan. *Id.*

Even before issuing the first disability check, MetLife set out to ensure that it could reduce some of its eventual outlay to Ms. Glenn. P.A. 11a; J.A. 145–47. As MetLife informed Ms. Glenn in October 2000, it had a right to offset any benefits it owed her by the full amount of any Social Security disability benefits she might recover. J.A. 147. Ms. Glenn had already filed an application with the Social Security Administration ("SSA") on her own initiative months earlier. A.R. 214. But MetLife was not content to let that pending SSA application run its course. Instead, MetLife directed Ms. Glenn to "contact Kennedy & Associates," a law firm specializing in Social Security benefits, "in the

near future," to ensure a favorable disability ruling. J.A. 146. Ms. Glenn acceded. A.R. 219.[2]

The Medical Leave Helps Ms. Glenn Stabilize but Not Enough to Return to Work

Ms. Glenn's medical leave had the stabilizing effect her doctors had hoped. P.A. 5a. Dr. Patel observed "some ... improvement" in Ms. Glenn's heart condition "*from the reduction of stress and strain of work.*" J.A. 84 (emphasis added); P.A. 5a. But Dr. Patel consistently concluded she was too sick to return to work. She "still gets fatigued out and short of breath," he opined, "particularly if she is under any kind of significant psychologic stress." J.A. 62.

Thus, at the four-month mark, Dr. Patel informed MetLife that Ms. Glenn would "*Never*" "be able to resume work" "*For Any Occupation.*" J.A. 110 (Aug. 2000) (emphasis added). He repeated that conclusion, in haec verba, at the six-month mark, J.A. 81 (Nov. 2000), after 15 months, J.A. 99 (June 2001), and after 20 months, J.A. 70 (Dec. 2001), each time adding she was "totally disabled." Neither Dr. Patel's notes nor his ample correspondence with her primary care physician ever

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[2] MetLife asserts that it "derive[d] no financial advantage" from assisting Ms. Glenn, because the plan authorizes MetLife to deduct SSA benefits "*if* the participant *does not actually apply* for social security benefits." Pet'r 52 (emphasis added). But Ms. Glenn *had* applied for benefits on her own. *See* A.R. 214. *But cf.* P.A. 3a (mistakenly suggesting otherwise). So the plan prohibited MetLife from reducing her benefits, unless the SSA awarded benefits. J.A. 168–69; A.R. 16–17. MetLife intervened because it stood to gain, not because it was on a charity mission.

wavered from this opinion. *See, e.g.*, J.A. 37–99, 105–11.

Ms. Glenn's Condition Remains Static, Despite an Aberrational "X" on a Form

The only hint to the contrary in Ms. Glenn's entire claim file was a lone "X" on an insurance form. The form, dated March 13, 2002, bears Dr. Patel's signature. J.A. 58. The form, which is different from all the others Dr. Patel had routinely signed, posed several stock questions. One of those questions was whether the insured is "able to work in a sedentary physical exertion level occupation." *Id.* An "X" is scrawled next to a pre-printed "yes." *Id.* The X-marked question did not specify that it was asking about returning to *full-time* work. *Id.* In the same form, Dr. Patel also reported on the number of hours a day Ms. Glenn could sit (8 hours), stand (4 hours), or walk (2 hours). *Id.* Had Dr. Patel scrutinized the form's boilerplate preamble, he might have discerned that MetLife would use the form to assess "her ability to return to full-time work," J.A. 57, but that is not what these questions asked. Nor did Dr. Patel explicitly state anywhere else on the form that—contrary to all his previous "Never" entries—Ms. Glenn had made a miraculous recovery and was ready to return to full-time work. J.A. 58.

To the contrary, on a "Physical Capacities Evaluation" form faxed along with the March form, J.A. 59, Dr. Patel stated, "*More* [Left Ventricular] Dysfunction Noted on Recent Echo," J.A. 61 (emphasis added), indicating that Ms. Glenn's condition was worsening. And at Ms. Glenn's most recent physical examination, a month earlier, Dr. Patel reported that she "continues to have exer-

tional shortness of breath on *any kind of emotional excitement* or any kind of significant physical exertion," and that her "[e]jection fraction," which measures the efficiency of the heart's pumping, "*again has gone back down* to 35–40%." J.A. 50–51 (emphasis added); *see* Pet'r 4 ("below 35% is considered poor").

As the Court of Appeals concluded, that lone X mark was "so inconsistent with other medical evidence and detailed reports supplied by Dr. Patel over a period of three years that it can best be described as aberrational." P.A. 16a. Within three months, Dr. Patel confirmed as much. On June 12, on another Physical Capacities Evaluation form, Dr. Patel reiterated his earlier view about Ms. Glenn's ability to sit, stand, and walk, J.A. 54, but he added the caution: "No emotional stress/no heavy exertion." J.A. 56. Contrary to MetLife's assertion, nowhere on this second form did "Dr. Patel ... conclude[] that [Ms.] Glenn could perform sedentary work." Pet'r 47. The form did not even ask the question (as the March 13 form had). J.A. 52–56. But just six days later, on June 18, Dr. Patel found it necessary to address the question anyway: He reported that she "was back in [his] office earlier than expected," due to "shortness of breath." J.A. 46. He examined her and declared—with the same certitude he had been expressing all along—"I do not believe she will handle any kind of stress well at her work and she would be better off being on disability." J.A. 47.

Contrary to MetLife's contentions, Pet'r 13, 45, 58, Dr. Patel took this position a month before MetLife terminated Ms. Glenn's benefits. J.A. 14.

MetLife Successfully Pursues SSA Disability Benefits

Meanwhile, on March 13, 2002—coincidentally, the very day of the fateful X mark—MetLife's preferred lawyers appeared before an administrative law judge ("ALJ") to argue that Ms. Glenn was too disabled to work *at any job*. P.A. 41a; J.A. 131–44. They insisted that "conservative and aggressive treatments have failed to provide long-term, consistent relief or improvement that would allow [Ms. Glenn] to return to a sustained level of work activity, *even at a sedentary exertional level*, without exacerbation of her cardiac dysfunction." J.A. 144 (emphasis added). In other words, they argued that *any* job would worsen Ms. Glenn's heart condition; she would be unsuitable "in even an unskilled work environment." J.A. 143. They supported this position with the reams of medical evidence MetLife had amassed as well as other medical information from Ms. Glenn's doctors. J.A. 131–44.

The ALJ agreed and ordered retroactive and prospective benefits on June 15, 2002. J.A. 13, 120; P.A. 41a–49a. He agreed that (as the relevant statute requires) Ms. Glenn could not "engage in *any* ... *kind* of substantial gainful work which exists in the national economy, regardless of [where] such work exists." 42 U.S.C. § 423(d)(2)(A) (emphasis added); P.A. 13a n.1, 47a.

MetLife allocated a fraction of the award for the lawyers and pocketed the rest. P.A. 11a; J.A. 118–19, 123.

MetLife Immediately Decides Ms. Glenn Is Not Disabled, After All

Less than a month after securing the ALJ's decision, on July 13, 2002, MetLife informed Ms. Glenn that it was now taking the opposite position against her: It concluded she *could* perform some *other* sedentary job. J.A. 14. That conclusion disqualified Ms. Glenn from benefits after the initial two-year disability period. After that mark, the plan—just like the SSA—required proof that she was "unable to perform the duties of *any* gainful work or service for which [she is] reasonably qualified" (as opposed to being unable to return to her previous job). P.A. 3a (alteration in original).

Why the about-face? MetLife blamed mainly the aberrational X. MetLife had enlisted an outside physician to review Ms. Glenn's cold file. A.R. 39. Seizing on the March report, the consultant attributed to *Dr. Patel* the conclusion that Ms. Glenn "could perform sedentary work." *Id.*; P.A. 30a. In terminating Ms. Glenn's benefits, MetLife said nothing of the SSA decision it helped obtain. J.A. 15. It was as if the SSA proceeding had never happened.

MetLife Persists in Denial, Ignoring Key Medical Information and the SSA Ruling

Ms. Glenn sought reconsideration. P.A. 31a. In support of the request, she submitted a letter from Dr. Patel, this one dated July 22, 2002, reaffirming his view by exclaiming: "I do not believe Wanda should be forced to return to any kind of *even sedentary work*." J.A. 44 (emphasis added). "[A]ny kind of psychologic stress at work," he emphasized,

"causes significant problems with her cardiovascular condition." P.A. 6a; J.A. 44 (emphasis added).

MetLife was unmoved. It denied reconsideration in August 2002. J.A. 29–33. In the denial letter, MetLife asserted—inexplicably—that "[t]here is no supportive medical documentation of the exacerbation of your cardiac condition and symptomology, due to subjective complaints of work-related stress." J.A. 31. MetLife did not mention Dr. Patel's consistent assertion that Ms. Glenn should "Never" return to work of any sort, or his July 22 letter insisting that Ms. Glenn was "completely disabled" and unable "to return to any kind of even sedentary work." J.A. 44, 45. So it felt no need to explain why these medical assessments did not qualify as "supportive medical documentation."

MetLife did, however, home in on other snippets of Dr. Patel's reports. It cited his November 2001 report that Ms. Glenn was "clinically stable" now that she was on leave, and, again, the aberrational X on the March 2002 form. J.A. 30. MetLife also fixated on a few words in Dr. Patel's June 18 report showing "an ejection fraction of 35 to 40%" (which is actually borderline "poor," Pet'r 4), but ignored his statement in the same report that Ms. Glenn should not return to work. J.A. 31; *see* J.A. 47. Once again, MetLife made no effort to reconcile its conclusion with the SSA ruling it helped produce.

Ms. Glenn appealed the denial through MetLife's internal review procedure. P.A. 31a. In support of the appeal, Dr. Patel issued yet another, more urgent letter, this one dated February 2003. J.A. 41–43. He acknowledged the aberrational X

mark on the March 2002 form, seeming to indicate "that the patient was fit for sedentary work." J.A. 42. But he insisted—consistent with everything he had said before and since—that "based on her clinical condition and her symptomology, *there was never a time* where I felt that this patient would be able to return to *full-time employment*." *Id.* (emphasis added). Directly rebutting MetLife's surmise that his opinion was based merely on "subjective complaints of work-related stress," J.A. 31, Dr. Patel protested: "Ms. Glenn does not have any emotional condition that causes her cardiac problem. She has a cardiac problem that is exacerbated by any kind of stress." *Id.*; J.A. 42. In sum, he definitively stated: "My position is that she should be considered completely disabled." J.A. 42.

In response, MetLife hired another outside consultant. P.A. 8a. He, too, merely reviewed the paper files. J.A. 37–40. As the Court of Appeals observed, the second consultant's "prognosis was, at best, ambiguous." P.A. 8a. On the one hand, he agreed that Ms. Glenn could not engage in "exertional physical activity," and that "[t]he actual impact of any form of real or perceived emotional stress [on Ms. Glenn's heart condition] is difficult to gauge in an individual patient." J.A. 39. On the other hand, he concluded that "the patient seems to be a reasonable candidate to try one of the sedentary job classes at least on a trial basis." *Id.*

This new consultant found support for his conclusion in Dr. Patel's evaluation from June 12, 2002. J.A. 38, 39. Nowhere in his evaluation did he refer to Dr. Patel's more explicit, and emphatic, conclusions from June 18, 2002, July 2002, and February 2003, insisting that Ms. Glenn was "com-

pletely disabled" and not able to work at "any kind" of job. P.A. 6a, 7a; J.A. 42. This omission led the Court of Appeals to conclude that he "[was] apparently not provided [by MetLife] with full information from Dr. Patel." P.A. 25a.

Despite the consultant's equivocation, MetLife issued a final denial of disability benefits in May 2003. J.A. 23–26; *see* P.A. 8a. Echoing its second consultant, MetLife relied upon the form Dr. Patel filled out on June 12, 2002. J.A. 24. This time, MetLife acknowledged Dr. Patel's February 2003 assertion that Ms. Glenn was "completely disabled," but did not explain why it was rejecting this emphatic position. J.A. 25. Instead, MetLife simply concluded, again, that the "documentation currently in the file does not support a disability that would prevent Ms. Glenn from performing any occupation." J.A. 25–26. MetLife completely ignored Dr. Patel's explicit finding of disability from June 18 and July 2002, his history of saying that she would "Never" be able to return to work, and the SSA decision.

The Court of Appeals Finds MetLife's Denial Arbitrary and Capricious

Ms. Glenn filed suit in federal court under ERISA for the benefits owed to her. *See* 29 U.S.C. § 1132(a)(1)(B); P.A. 8a–9a. The District Court upheld MetLife's denial of benefits. Although it stated that it would consider MetLife's "conflict of interest ... as a factor," it applied a "deferential arbitrary and capricious standard of review." P.A. 32a–34a, 40a.

The Court of Appeals reversed. P.A. 25a–26a. The court held that MetLife's decision "can only be

described as arbitrary and capricious." P.A. 25a. It was neither "the result of a deliberative process" nor "based on substantial evidence." P.A. 2a. The court observed that MetLife's status as a dual-role insurer "creates an apparent conflict of interest," and that conflict was a "'facto[r]'" to be considered. P.A. 10a (quoting *Firestone*, 489 U.S. at 115). But the conflict was only one of a bevy of factors. The court detailed at least seven *other* flaws in MetLife's decision—describing four of them as "arbitrary" in their own right. *See infra* at 54–55 (enumerating the flaws).

On remand, the District Court found MetLife's "culpability ... high" and ordered MetLife to pay Ms. Glenn's attorneys' fees and costs. *Glenn v. MetLife*, 2007 U.S. Dist. LEXIS 3421, at *12 (S.D. Ohio Jan. 8, 2007).

SUMMARY OF ARGUMENT

I. This case presents an obvious conflict of interest. As a dual-role insurer for Sears's employee disability plan, MetLife has a financial stake in every claim for benefits that is submitted under the plan. There is nothing "potential" about MetLife's financial interest. Every time MetLife concludes that a claimant is entitled to benefits under the plan, it must reach into its own pocket and pay those benefits. Conversely, every time MetLife denies a claim, it saves the money it would have paid the employee—as it did with Ms. Glenn.

Nevertheless, MetLife insists that a court is forbidden even to consider the conflict in reviewing a benefit denial under 29 U.S.C. § 1132(a)(1)(B). Most circuits disagree with MetLife's position. That is because MetLife's position find no support

in ERISA or its underlying policies, in this Court's precedent, or in trust law.

ERISA does not prohibit a court from weighing a dual-role conflict when reviewing a benefit denial claim. All ERISA says is that it will not "*prohibit* any fiduciary" from serving a dual role. 29 U.S.C. § 1108(c)(3) (emphasis added). As this Court held in *Firestone*, Congress said nothing about how courts should scrutinize a benefit denial. Rather, ERISA imports trust law to define the standard of review. Trust law says exactly what this Court observed in *Firestone*: When a trustee operates under a conflict of interest, "that conflict *must* be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (quoting SECOND RESTATEMENT § 187, cmt. d (emphasis added)).

In fact, trust law speaks directly to both questions presented. The most explicit statement in the most current and definitive distillation of trust law describes how courts should account for a bare conflict: Whenever bare "conflict-of-interest situations exist"—i.e., even when there is no additional evidence that the conflict affected the fiduciary's decision—"the conduct of the trustee in the administration of the trust will be subject to *especially careful scrutiny*." RESTATEMENT (THIRD) OF TRUSTS § 37, cmt. f(1) (2001) (emphasis added) ("THIRD RESTATEMENT").

ERISA's goals support the result dictated by trust law. The statutory goal that dominated the Court's opinion in *Firestone* was "to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." 489 U.S. at 113 (citations

and internal quotation marks omitted). As in *Firestone*, this concern supports careful scrutiny. *Firestone* held that the default rule in an ERISA case is *de novo*, because otherwise employees would have less protection than they had pre-ERISA. The same is true here. If a court must give a dual-role insurer utmost deference, without any consideration of the conflict, an employee who was the victim of an improperly motivated benefit denial would be much worse off than he would have been with a contract claim under ERISA.

MetLife worries that diminished deference leads to higher costs and more frivolous litigation. This Court considered and rejected those arguments when it chose *de novo* review as ERISA's default standard. The arguments are even less compelling in a dispute over standards for a conflicted fiduciary. In any event, the rule MetLife opposes has been in place for decades in most courts, and no such dire consequences have materialized.

Equally meritless are MetLife's various other arguments against weighing the conflict. None of the supposed business realities MetLife invokes was enough to prevent UnumProvident—the largest disability insurer in the nation—from denying meritorious claims on a massive scale in pursuit of maximum profits. Similarly, arbitrary-and-capricious review will not suffice to guard against an insurer's conscious or subconscious shading of benefit decisions. And state and federal administrative agencies do not, and are not expected to, protect individual claimants. Congress prescribed complementary roles for *both* regulators and judges. While regulators provide *systematic* over-

sight, Congress gave judges the responsibility to review individual claims for benefits due—like this one—under § 1132(a)(1)(B), and to do so in a way that advances both ERISA's goal of protecting claimants' contract rights and its unwaivable requirement that plan fiduciaries act in the sole interest of beneficiaries.

II. Trust law leaves no doubt that a court must apply "especially careful scrutiny" to a benefit denial simply because there is a conflict. THIRD RESTATEMENT § 37, cmt. f(1). This is a deferential standard. Nevertheless, courts applying this standard routinely re-weigh the evidence to ascertain for themselves whether the trustee's position is outside the range of reasonableness they would expect from an unconflicted trustee. Beyond that, courts should (1) demand complete and careful explanations; (2) cast a skeptical eye on the explanations they do receive; and (3) exhibit little tolerance for analytical flaws or evidentiary gaps.

When scrutiny exposes *additional* reasons to suspect that the conflict may have affected the insurer's decision, deference should diminish accordingly—all the way to *de novo* review when the suggestion of improper motive is strong.

The burden of persuasion need not shift to the insurer. But the burden of production should shift to the insurer, if the insurer wishes to argue (as MetLife does here) that it structures its business practices in a way that shields claimants from any conflict.

Finally, this Court should affirm, because the Court of Appeals left no doubt that it would reject MetLife's benefit determination under any stan-

dard of review. While the Court of Appeals considered the conflict as a "factor," it did not purport to diminish the deference it was giving MetLife. Moreover, the court's conclusion that MetLife's decision was arbitrary and capricious was based on seven additional factors—four of which the court described as "arbitrary' in their own right. In light of the Court of Appeals' analysis, a remand would be wasteful.

ARGUMENT

I. A DUAL-ROLE INSURER OPERATES UNDER A CONFLICT OF INTEREST THAT A COURT SHOULD CONSIDER IN REVIEWING BENEFIT DENIALS.

When a lawyer has a financial stake in an opposing party, he has a conflict of interest. *See* Model R. Prof. Conduct 1.7(a) (2004). When a judge owns stock in a party before her, she has a conflict of interest. *See* 28 U.S.C. § 455(b)(4). When an umpire bets on the outcome of a game he is refereeing, he has a conflict of interest. *See* Major League Baseball Rule 21(d).

MetLife is equally conflicted when it decides whether a beneficiary is entitled to benefits. If MetLife answers "yes," then it is the one who has to pay; the beneficiary's gain is MetLife's loss. MetLife "is exercising discretion over a situation for which it incurs 'direct, immediate expense as a result of benefit determinations favorable to [p]lan participants.'" *Brown v. Blue Cross & Blue Shield of Ala., Inc.*, 898 F.2d 1556, 1561 (11th Cir. 1990) (quoting *de Nobel v. Vitro Corp.*, 885 F.2d 1180, 1191 (4th Cir. 1989) (alteration in original)). That is the classic definition of an "economic conflict of

interest by [a] fiduciary," under trust law—and common parlance. *Id.*; *see infra* at 23–27. As much as MetLife tries to minimize the conflict, it never comes out and says, "The financial arrangement is not a conflict of interest."

Nor could it. Newspapers, regulators, and judges have fully documented the unfortunate reality that dual-role insurers, succumbing to the conflict, have improperly denied benefits to boost profits—sometimes on a massive scale. The most notorious offender that has been exposed is UnumProvident—the country's dominant disability insurer. *See generally* John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315 (2007) (documenting the scandal). It had "a company-wide practice of denying claims based on UnumProvident's current profits," *Bennett v. Unum Life Ins. Co. of Am.*, 321 F. Supp. 2d 925, 933 (E.D. Tenn. 2004), yielding "a disturbing pattern of erroneous and arbitrary benefits denials, bad faith contract misinterpretations, and other unscrupulous tactics," *Radford Trust v. First Unum Life Ins. Co. of Am.*, 321 F. Supp. 2d 226, 247 & n.20 (D. Mass. 2004) (collecting citations to numerous previous cases), *rev'd in part on other grounds*, 491 F.3d 21 (1st Cir. 2007). The profit motive infected benefit decisions in subtle—and not so subtle—ways:

> Claims managers and handlers are given a quota of how many claims need to be ... denied, in a given period for the company to remain at a certain level of profitability. Medical advisors ... are offered bonuses at a

> level of 25% base pay determined, in part, on company earnings.... Claims handlers, ... supervisor[s], and even other doctors employed by UnumProvident pressured [medical personnel] to ... to deny claims.

Bennett, 321 F. Supp. 2d at 933–34. As MetLife acknowledges, regulators concluded that the conflict of interest could have tainted as many as 200,000 claim denials. Pet'r 37.

Unum is not alone in sacrificing beneficiaries' claims on the altar of profits. As the California Insurance Commissioner has observed, "[t]his is not just a UnumProvident problem; it's an insurance industry one." *See, e.g.*, Peter G. Gosselin, *The New Deal: The Safety Net She Believed In Was Pulled Away When She Fell*, L.A. Times, Aug. 21, 2005, at A1. The National Association of Insurance Commissioners agrees. *See generally* NAIC Br. As Professor Langbein documents, "[c]ases of abusive benefit denials involving other disability insurers abound." Langbein, 101 NW. U. L. REV. at 1321–22 & n.41 (collecting cases). In one notable example, the Eighth Circuit recounted how Aetna engaged in some of the same unscrupulous practices as Unum, "[a]pparently to limit claim payments." *Armstrong v. Aetna Life Ins. Co.*, 128 F.3d 1263, 1265 (8th Cir. 1997). "The danger pervades the ERISA-plan world that a self-interested plan decisionmaker will take advantage of its license under [*Firestone*] to line its own pockets by denying meritorious claims.... Unum turns out to have been a clumsy villain, but in the hands of subtler operators such misbehavior is much harder to detect." Langbein, 101 NW. U. L. REV. at 1321.

The conflict of interest does not mean that every benefit decision Unum or Aetna—or MetLife—makes is wrong. It does not even mean that the dual-role insurer consciously shades every decision with self-interest. But it does mean that there is always a risk that "subtler operators" are occasionally indulging their own financial interests at the expense of claimants, especially on closer claims, *id.*, and that a conflicted fiduciary, like any other conflicted decisionmaker, "may favor, consciously or unconsciously, its interests over the interests of the ... beneficiaries." *Brown*, 898 F.2d at 1565; *see* GEORGE BOGERT ET AL., THE LAW OF TRUSTS & TRUSTEES § 543 (rev. 2d ed. 1993) ("BOGERT ON TRUSTS").

So the question in this case is not whether the dual-role insurer operates under a conflict of interest. Of course, it does. The question, as MetLife poses it, is whether this is the *sort* of "'conflict of interest' that must be weighed in a judicial review of the administrator's benefit determination." Pet'r i. MetLife's position is that courts reviewing the decisions of dual-role insurers are legally required to *completely ignore* this conflict of interest in assessing how much to defer to an insurer's decision to deny benefits in an ERISA case. *See* Pet'r 21–29. Most circuits to address the question disagree with MetLife, *see* U.S. Cert. Br. 7–8 (documenting 7-3 split), as does the Government, *see generally* U.S. Br. The majority rule is consistent with this Court's precedent, with trust law, and with the policies underlying ERISA. MetLife's arguments for rejecting the majority rule are unpersuasive.

A. As This Court Has Held, Congress Did Not Prescribe How to Review the Decisions of a Dual-Role Insurer, but Trust Law Provides the Answer.

1. Everyone agrees the most explicit statement Congress made about dual-role fiduciaries is this: ERISA should not be construed "to *prohibit* any fiduciary from ... serving as a fiduciary in addition to being an officer, employee, agent, or other representative of a party in interest." 29 U.S.C. § 1108(c)(3) (emphasis added). As MetLife acknowledges, this provision "*authorizes*" the dual role. All that means is that the conflict is *not illegal*. Pet'r 21, 22. Congress did not, however, say anything about how much courts should defer to an insurer operating under such a conflict.

In fact, in *Firestone*, this Court held that ERISA says nothing at all about standards of review for benefit denials. There, this Court adopted *de novo* review as the default standard in ERISA cases. 489 U.S. at 115. That case, too, involved a fiduciary that both determined what benefits were due and paid those benefits out of its own pocket. *Id.* at 105. The central question in the case was "the appropriate standard of review in actions under § 1132(a)(1)(B)"—actions, like this one, to recover benefits. *Id.* at 108.

As this Court acknowledged, "most federal courts ha[d] reviewed the denial of benefits by ERISA fiduciaries and administrators under the arbitrary and capricious standard," but "the arbitrary and capricious standard had been softened in cases where fiduciaries and administrators had some bias or adverse interest." *Id.* at 107. In that very case, the court of appeals had held that a dual-

role fiduciary is entitled to *no* deference, on account of the conflict. *Id.* at 107–08. This holding was the central battleground in the case—at least among the parties.

The Court concluded that "the wholesale importation of the arbitrary and capricious standard into ERISA is unwarranted." *Id.* at 109 (emphasis omitted). In so ruling, this Court set forth the principles that control here. It began, as noted above, with the observation that "ERISA does not set out the appropriate standard of review for actions under § 1132(a)(1)(B) challenging benefit eligibility determinations." *Id.* It then described how courts should fill the void: "In determining the appropriate standard of review for actions under § 1132(a)(1)(B), we are guided by principles of trust law." *Id.* at 111.

This Court discerned three black-letter rules from trust law. Rule 1 is the default ERISA rule, where the plan does not say that the administrator's "eligibility determinations are to be given deference": In that context, "settled principles of trust law ... point to *de novo* review." *Id.* at 111–12.

The other two rules govern the situation where the plan does say that the fiduciary's benefit decisions are discretionary. Rule 2, for an *unconflicted* trustee, is that "[t]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers" under the terms of the plan. *Id.* at 111 (citing SECOND RESTATEMENT § 187).

Rule 3 is the one relevant here, for it relates to *conflicted* fiduciaries: "Of course, if a benefit plan gives discretion to an administrator or fiduciary

who is operating under a conflict of interest, *that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'*" *Id.* at 115 (quoting SECOND RESTATEMENT § 187, cmt. d (emphasis added)).

2. This last passage reciting Rule 3 has been a touchstone in every circuit that has grappled with the question presented here. Yet, MetLife scarcely mentions it. MetLife dismisses the passage asserting that "the Court did not purport to determine which categories of conflicts of interest should be taken into account on judicial review." Pet'r 26. The only natural reading of the passage is that the rule applies to *any* conflict of interest. But even if one might imagine exceptions, one fact is certain: At the forefront of the Court's mind when it articulated Rule 3 was the sort of conflict that was at the heart of that very case—a dual-role fiduciary.

Despite this Court's unmistakable direction, MetLife insists that "[i]t defies logic to suggest that[] ... Congress would have expressly permitted the same entity to evaluate and pay claims if it believed that vesting both responsibilities in a single body would create a conflict of interest detrimental to plan participants." Pet'r 22. No one is suggesting that a dual-role conflict is *necessarily* "detrimental to plan participants," but only that this conflict of interest, like any conflict, *could* be detrimental to *some* plan participants *if not properly monitored*. Far from "def[ying] logic," that is exactly what trust law prescribes, as we demonstrate in the next section.

Contrary to MetLife's assertion, *Pegram v. Herdrich*, 530 U.S. 211 (2000), does not retreat from the rule this Court articulated in *Firestone*.

And it certainly does not, as MetLife claims, set out the diametrically opposite general rule that a "fiduciary's ... financial interest in a benefit determination does not, standing alone, constitute a conflict of interest that should affect the standard of review." Pet'r 22. This Court emphasized that it "ha[d] no occasion to discuss" the standard of review that applies to a dual-role beneficiary like MetLife. *Pegram*, 530 U.S. at 229 n.9. The Court held only that when an HMO physician makes a treatment decision that implicates eligibility, the physician is not engaged in a fiduciary act under ERISA. *Id.* at 231. As this Court later emphasized, a "benefit determination under ERISA ... is generally a fiduciary act," *Aetna Health Inc. v. Davila*, 542 U.S. 200, 218 (2004)—it certainly is here—so *Pegram* is a narrow exception applicable only to "a treating physician or such a physician's employer," *id.* at 221.

Outside that limited context, the rule is as *Firestone* declared, that "[o]f course ... a conflict of interest must be weighed as a 'facto[r].'" 489 U.S. at 115 (quoting SECOND RESTATEMENT § 187, cmt. d). Referring to that very sentence, MetLife inveighs, "*Firestone* ... authoritatively forecloses" any contrary view. Pet'r 42. "There is no reason to revisit that conclusion here." Pet'r 43. So stipulated.

B. This Court Correctly Concluded That, Under Trust Law, a Fiduciary's Authorized Conflict of Interest Must Be Weighed as a Factor in Reviewing the Fiduciary's Decision.

1. This Court was correct about trust law. Generally, trust law prohibits a trustee from oper-

ating under a conflict of interest at all. BOGERT ON TRUSTS § 543. But trust law authorizes the settlor who creates a trust to appoint a trustee with a financial conflict, if that is what the settlor wishes. *See, e.g., id.*; AUSTIN SCOTT & WILLIAM FRATCHER, THE LAW OF TRUSTS § 107.1 (4th ed. 2001) ("SCOTT ON TRUSTS").

Just because a settlor is allowed to appoint a conflicted trustee, however, does not mean that the courts must ignore the conflict in reviewing the trustee's actions. The law has long been that, in the interest of protecting beneficiaries, the court must weigh that conflict as a factor in reviewing the trustee's actions. The Third Restatement of Trusts reports the rule as follows:

> [T]here will inevitably be some *conflicts of interest that are approved* ... , implicitly at least, ... by the settlor .... In these circumstances there is, on the one hand, some inference of a preference for or confidence in the trustee-beneficiary but, on the other hand, a general recognition that a trustee-beneficiary's conduct is to be *closely scrutinized* for abuse, including abuse by less than appropriate regard for the duty of impartiality.

THIRD RESTATEMENT § 79, cmt. b(1) (emphasis added).

The passage this Court cited from the Second Restatement—comment d to § 187—articulates the same rule. By way of context, comment d is appended to the general principle that: "Where discretion is conferred upon the trustee with respect to the exercise of a power, its exercise is not

subject to control by the court, except to prevent an abuse by the trustee of his discretion." *Id.* § 187. Comment d, titled "Factors in determining whether there is an abuse of discretion," enumerates several "circumstances" that "may be relevant" to that determination. One of them is "the existence or nonexistence of *an interest* in the trustee *conflicting* with that of the beneficiaries." *Id.* § 187, cmt. d (emphasis added); *see* SCOTT ON TRUSTS § 170.23A (same).

Both the Second and the Third Restatements illustrate this authorized-conflict exception with classic trust law scenarios:

> A bequeaths all of his property to B, his son, in trust to pay the income and so much of the principal as in his discretion shall be necessary for the support and comfort of C, A's widow, and on C's death to hold the property or what remains thereof free of trust. The court will not remove B as trustee or refuse to confirm his appointment as trustee because of his conflicting interest. Such conflicting interest is, however, a *factor to be considered* by the court in determining later whether in administering the trust B is guilty of an abuse of discretion in failing to pay C sufficient [funds] for her support and comfort.

SECOND RESTATEMENT § 107, cmt. f, illus. 1 (emphasis added); *see also* THIRD RESTATEMENT § 50, cmt. b, illus. 1 (similar illustration).

In this classic scenario, the trustee operates under the same sort of dual-role financial conflict of interest as MetLife: The son is both trustee and

beneficiary—a "trustee-beneficiary," as the Third Restatement puts it. Every penny the son spends for the "support and comfort" of his father's widow, diminishes the remainder he enjoys upon her death, just as every penny MetLife spends in paying a claim diminishes MetLife's bottom line. This conflict of interest would ordinarily disqualify the son from serving as trustee. But the trustee may serve, because the settlor, aware of the conflict, has authorized the appointment, just as MetLife may serve because the employer has done the same. An employer is allowed to make that choice because ERISA expressly authorized it to do so, just as the settlor is allowed to make that choice because trust law expressly authorizes him to do so. The son's authorized dual-role conflict is so analogous to MetLife's that a leading authority on trusts treats them as equivalent. BOGERT ON TRUSTS § 255 n.54.

Not only is this sort of dual-role conflict a "factor to be considered," but the Restatements clarify that this factor modifies the standard of review for a conflicted trustee: "[W]hen a beneficiary serves as a trustee or when other conflict-of-interest situations exist, the conduct of the trustee in the administration of the trust will be subject to *especially careful scrutiny*." THIRD RESTATEMENT § 37, cmt. f(1) (emphasis added); *id.* § 50, cmt. b, illus. 1 ("his acts are to be carefully scrutinized for abuse"); *id.* § 79, cmt. b(1) ("closely scrutinized for abuse"); SECOND RESTATEMENT § 107, cmt. f ("sub-

ject to careful scrutiny"). Trust law cases applying this rule are legion.[3]

Thus, MetLife is wrong when it protests that "it cannot be the case" that the law can allow an employer to "authorize" a conflict, but nevertheless "change[] the standard of review" when the employer does. Pet'r 21. That *is* the case, at least under trust law.

2. MetLife declares that "trust-law principles ... confirm that, without more, the fact that the same entity both evaluates and pays claims does not create a conflict of interest that must be weighed on judicial review." Pet'r 23. The only way to make that statement true is to attack the Restatement of Trusts with an Exacto knife and copious amounts of Wite-Out—and then turn those editing tools on scores of trust law cases.

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[3] *See, e.g.*, *White Mountain Apache Tribe v. United States*, 249 F.3d 1364, 1379 (Fed. Cir. 2001) ("The court must be particularly careful in scrutinizing ... [a]ctions of [a conflicted] trustee ...."), *aff'd*, 537 U.S. 465 (2003); *In re Peabody's Will*, 96 N.Y.S.2d 556, 561 (Sup. Ct. 1950) (when trustee operates under an authorized conflict, "his conduct in administering the trust will be more closely scrutinized"), *aff'd*, 98 N.Y.S.2d 614 (App. Div. 1950); *In re Heller*, 849 N.E.2d 262, 265–66 (N.Y. 2006) ("scrutinized by the courts with special care"); *Mesler v. Holly*, 318 So. 2d 530, 533 (Fla. App. 1975) (conflicted trustee's "discretion ... becomes particularly vulnerable to a challenge by" other beneficiaries); *In re Estate of McCart*, 847 P.2d 184, 185–87 (Col. Ct. App. 1992) (applying close scrutiny to conclude that trustee-beneficiary abused discretion); *In re Buchar's Estate*, 74 A. 237, 238 (Pa. 1909) (same); *Garvey v. Garvey*, 22 N.E. 889, 890 (Mass. 1889) (same).

The trust law authorities quoted above—including the one this Court quoted in *Firestone*—simply cannot be reconciled with MetLife's oft-repeated central theme that a dual-role conflict "cannot be weighed ... unless the [beneficiary] makes a showing that the fiduciary in fact acted on the basis of its own financial interests when carrying out its fiduciary responsibilities." *Id.*; *see* Pet'r 25, 33.

As is evident from the Restatement illustrations quoted above, the rule of heightened scrutiny revolves around "*the mere fact* that the trustee named by the settlor is one of the beneficiaries of the trust." SECOND RESTATEMENT § 107, cmt. f (emphasis added); *id.* § 107, cmt. f, illus. 1; THIRD RESTATEMENT § 37, cmt. f(1) (more scrutiny "when ... conflict-of-interest situations *exist*" (emphasis added)). In fact, when a court concludes that a conflict of interest actually has (as MetLife puts it) "infected the trustee's determination," Pet'r 26, the consequence is not just diminished deference, but *no* deference, *see, e.g.*, *Pollok v. Phillips*, 411 S.E.2d 242, 244–45 (W. Va. 1991); *In re Estate of Manahan*, 125 N.W.2d 135, 138 (Iowa 1963).

In support of its contrary view, MetLife pieces together various unrelated trust principles into the legal equivalent of a skid-row shanty. *See generally* Profs. Br.

First, MetLife cites numerous cases that stand only for the principle—not disputed here—that a court will not *remove* a trustee for a conflict of interest that the settlor has authorized. *See* Pet'r 24 n.5, 25 n.6 (citing *Estate of Freuhauf v. Comm'r of Internal Revenue*, 427 F.2d 80, 86 (6th Cir. 1970); *In re Pincus' Estate*, 105 A.2d 82, 86–87 (Pa.

1954); *In re Estate of Gilliland*, 140 Cal. Rptr. 795, 802 (Ct. App. 1977)).

Second, MetLife repeatedly invokes the general rule that "[f]iduciaries should ... be presumed to faithfully discharge their obligations in the absence of an appropriate showing ... indicating that the fiduciary's decision was actually based on an improper motive." Pet'r 33 (citing SECOND RESTATEMENT § 187, cmt. g); *see also* Pet'r 24 (quoting *Shelton v. King*, 229 U.S. 90, 94–95 (1913)). MetLife cites a famous case, involving an *unconflicted* trustee, and a Restatement passage confirming that this is "ordinarily" the rule—for *unconflicted* fiduciaries. The passage goes on to reiterate the point that the mere "fact that the trustee has an interest conflicting with that of the beneficiary is to be considered" when assessing "improper motive." SECOND RESTATEMENT § 187, cmt. g.

Third, at every turn, MetLife mischaracterizes a dual-role conflict as "a *potential* conflict," as distinguished from "an *actual* conflict." Pet'r 26; *see, e.g.*, Pet'r 25, 40. MetLife's unstated premise is that an actual conflict is one that can be proven to have affected the fiduciary's behavior, whereas a potential conflict is one that cannot. Any such notion is foreign to trust law (and any other rational body of law governing conflicts). Under trust law, an actual conflict is merely "*an interest* in the trustee conflicting with that of the beneficiaries." SECOND RESTATEMENT § 187, cmt. d (emphasis added). In contrast, a potential conflict is where the fiduciary does not *currently* have an adverse interest, but the adverse interest *might* later materialize based upon contingencies that may or may

not come to pass. *See, e.g.*, SCOTT ON TRUSTS § 170.23A. As is evident from the Restatements, treatises, and trust cases quoted above, a dual-role conflict is an actual conflict, because "the administrator has an interest (e.g., in profit or a better bottom line) that is adverse to the interests of beneficiaries seeking payment." *Post v. Hartford Ins. Co.*, 501 F.3d 154, 163 (3d Cir. 2007). Labels aside, there is no question that the very existence of the dual-role status—by whatever name—is a factor that must be considered under trust law.

Finally, MetLife invokes the inapposite trust principle that a settlor may choose to authorize a trustee to engage in *specified transactions* that would otherwise be condemned as self-dealing. Pet'r 23–24. As MetLife points out, this means that "[b]y the terms of the trust the trustee may be permitted," for example, "to sell trust property to himself individually." SECOND RESTATEMENT § 170, cmt. t (quoted at Pet'r 24); *see* Pet'r 24 n.5 (citing numerous such cases involving specific transactions). In those circumstances, the trustee has waived the duty of loyalty, and the fiduciary, by definition, is not acting solely in the beneficiaries' interests.

MetLife does not assert that ERISA authorizes dual-role insurers to engage in self-dealing. And for good reason: Regardless of what the "settlor" (i.e., employer) might consent to, the statute requires a fiduciary always to "discharge his duties with respect to a plan *solely in the interest of the participants and beneficiaries* and for the *exclusive purpose* of providing benefits to participants and their beneficiaries." 29 U.S.C. § 1104(a)(1)(A)(i) (emphasis added); *see, e.g.*, *Pe-*

gram, 530 U.S. at 235. So these self-dealing cases are inapplicable. But even if they were applicable, the courts still scrutinize authorized self-dealing transactions. *See* Profs. Br. §§ II.A–B; *Del. ex rel. Gebelein v. Belin*, 456 So. 2d 1237, 1239–41 (Fla. 1984); *In re Estate of Halas*, 568 N.E.2d 170, 177–79 (Ill. App. Ct. 1991).

C. ERISA's Goals Support Consideration of Dual-Role Conflicts on Judicial Review.

1. This Court had ERISA's policies firmly in mind when it opined in *Firestone* that a "conflict must be weighed" on judicial review of a benefit denial. 489 U.S. at 115. The Court invoked these goals in support of its holding that *de novo* review is the default standard for judicial review of benefit denials. The statutory goal that dominated the Court's opinion was that "ERISA was enacted 'to promote the interests of employees and their beneficiaries in employee benefit plans,' and 'to protect contractually defined benefits.'" *Id.* at 113 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983), and *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985)); *see generally* Profs. Br. § III.

A deferential default standard, the Court held, would undermine this goal, because it "would afford *less* protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Firestone*, 489 U.S. at 114 (emphasis added). As the Court understood, in the pre-ERISA world, employees had the right to bring state-law contract claims for the denial of promised benefits, and those claims would be subject to *de novo* review. *Id.* at 113–14. Congress eliminated their state-law claims. But it is inconceivable that

Congress intended to replace those claims with a regime in which the fiduciary could decide the employees' contract rights and be almost entirely immunized from judicial scrutiny.

The same criticism applies with greater force here. Before ERISA, when an employee sued an insurance company for benefits, the court would not only have subjected the denial to *de novo* review, but it would have resolved any contractual ambiguity *against* the insurer. 2 G. COUCH, R. ANDERSON, & M. RHODES, COUCH ON INS. 2D § 15:83, at 399 n.4 (rev. ed. 1984) (citing cases from the District of Columbia and 47 states, with no contrary authority). These protections shielded the employee from any possibility that the insurer's profit motive—consciously or subconsciously—affected its decision. It seems just as inconceivable that, in eliminating the contract action against an insurer who succumbs to a conflict, Congress intended *also* to eliminate the reviewing court's ability to detect the injustice.

2. MetLife acknowledges that "dual policies underl[ie] ERISA." Pet'r 26. But the interest that dominated this Court's opinion in *Firestone* is absent from MetLife's brief—except for a seven-word cameo, vaguely noting that one goal is "to protect the interests of plan participants." *Id.* Instead, MetLife lavishes attention only on the countervailing goal, "to facilitate the formation of employee benefit plans by minimizing the administrative and financial burdens on plan administrators." *Id.* (internal quotation marks omitted). Even if dwelling on half the balance were appropriate, MetLife's analysis of that half is unpersuasive, and has largely been rejected by the Court already.

First, MetLife extols the virtues of "[t]he consolidation of claims administration and funding responsibilities within a single company." Pet'r 26. But no one is advocating a rule (as MetLife put it in its petition) "to discourage employers from appointing claims administrators that also fund the plan." Pet. 11. The rule allowing courts to consider a dual-role conflict as a factor in reviewing benefit denials does not discourage dual-role fiduciaries any more than a rule allowing courts to scrutinize the decisions of a dual-role trustee discourages fathers from making their sons both trustees and beneficiaries. In either context, the rule simply allows courts to play their customary role of protecting beneficiaries from the possibility that the trustee's conflict might hurt them.

In any event, MetLife's emphasis on costs and administrative burdens would be an argument (as it was in *Firestone*) for applying the most deferential standard of review to all fiduciaries, in all circumstances. This Court rejected the argument, opting instead for a default rule that gives *no* deference. *See Firestone*, 489 U.S. at 115. Those same goals cannot now support a rule of utmost deference in more specific circumstances, particularly not in circumstances where trust law demands careful scrutiny. *Cf. Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 385 (2002) ("Not only is there no ERISA provision directly providing a lenient standard for judicial review of benefit denials, but there is no requirement necessarily entailing such an effect even indirectly.").

Next, MetLife predicts that anything less than full deference "will inevitably encourage participants with dubious claims to file suit," and will

force fiduciaries to *grant* meritless claims. Pet'r 27 & n.8. This Court rejected this argument, too, in *Firestone*, when it chose a standard that, by the same theory, would encourage even more dubious claims and unwarranted grants. *See* 489 U.S. at 115. As this Court held, "the threat of increased litigation is not sufficient to outweigh the reasons for a *de novo* standard that we have already explained." *Id.*

Apart from this Court's authoritative response, there is also a practical response to MetLife's parade of horribles: For the past 20 years, most courts have been weighing the conflicts of dual-role insurers on review of benefit denials. There is no evidence that employers have shunned insurance companies, that meritless litigation has swamped the courts, or that fiduciaries are granting *too many* claims. If the horribles have lain dormant for two decades, they are not likely to rear their heads when this Court adopts the majority rule.

D. MetLife's Other Arguments for Utmost Deference Are Unpersuasive.

MetLife makes several other arguments for departing from the rules dictated by trust law and supported by ERISA's goals. Each is unpersuasive.

1. Business "realities." MetLife expounds at length on business "realities" in the insurance industry. Pet'r 29–33. But none of these supposed realities sufficiently protects beneficiaries. The leading trust law scholar in the nation has dissected and authoritatively refuted each argument. *See* Langbein, 101 NW. U. L. REV. at 1327–31; *see also* UP Br. §§ I.A–I.C. We briefly respond to each.

First, MetLife argues, in essence, "we aim to please": Insurers have "long-term business incentives to treat claimants fairly," lest they lose "dissatisfied customers." Pet'r 29–30 (internal quotation marks omitted). But this dynamic is worthless unless employees and employers police millions of claim denials. They do not and cannot. *See Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 388 (3d Cir. 2000); Langbein, 101 NW. U. L. REV. at 1328–29.

Second, MetLife observes that "several courts have noted [that] individual claims are often quite minute when compared with" the billions in profits of "supposedly conflicted decision-makers." Pet'r 30. Here is how one such court put this drop-in-the-bucket argument: "Unum is much too large to be affected by its resolution of any one benefits claim." *Shyman v. Unum Life Ins. Co.*, 427 F.3d 452, 455 (7th Cir. 2005) (Easterbrook, J.). That was obviously wrong. MetLife is urging this Court to make the same mistake the Seventh Circuit made: to ignore the obvious point that MetLife is engaged in a high-volume business. If an airline finds it profitable to skimp with trivial cost-cutting measures—for example, by substituting pretzels for peanuts—then an insurance company processing thousands of claims can find profit in skimping on meritorious claims like Ms. Glenn's $350,000 claim.

Third, MetLife argues that not "every dollar that the insurance company pays in benefits" necessarily "comes directly out of its profits." Pet'r 30. But all MetLife actually demonstrates is that dual-role insurers can still make a profit without succumbing to the conflict. It does not deny that

cheating beneficiaries could *increase* profits even more, by suppressing costs. *See Pinto*, 214 F.3d at 388; Langbein, 101 NW. U. L. REV. at 1330–31.

Finally, in a variation on the old saw, MetLife argues that insurance companies don't deny claims, agents do. Agents, MetLife asserts, "do not have direct personal stakes in the outcome of their decisions." Pet'r 31. That is obviously false for insurers that give bonuses based on profits or that pressure adjusters to deny claims. *See supra* at 17–18; *see generally* Langbein, 101 NW. U. L. REV. 1315. Even while Unum was meting out improper denials by the thousands, courts were holding that "[n]othing in our record suggests that UNUM has even tried" to adopt incentives for employees to deny claims in the interest of maximize profits. *Perlman v. Swiss Bank Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981 (7th Cir. 1999). As to the other insurers, MetLife does not cite any authority for the novel proposition that trust law or ERISA distinguishes a conflicted trustee from its agents.

Contrary to MetLife's analogy, *see* Pet'r 31, insurance adjusters, who resolve the financial interests of their own employers, are nothing like ALJs, who are public employees bound by "a well established set of procedural protections that stem from the Constitution and individual statutes." *Ramsey v. Hercules Inc.*, 77 F.3d 199, 205 (7th Cir. 1996); *see* Mark D. DeBofsky, *The Paradox of the Misuse of Administrative Law in ERISA Benefit Claims*, 37 J. MARSHALL L. REV. 727, 738–43 (2004). To take one obvious example, unlike claims adjusters, ALJs are required to give claimants a full and fair hearing replete with all the

trappings of an adversarial adjudicative process. *See Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 332 (7th Cir. 2000) (Posner, J.). Notably, "when the initial decision in an agency lacks the crucial procedural safeguards, the Administrative Procedure Act requires the federal courts to review both fact and law *de novo*." *Ramsey*, 77 F.3d at 205. Thus, under the administrative law paradigm, claims adjusters would get *no* deference.[4]

All four of these arguments fail at an even more fundamental level: They do not negate the conflict; at most, they might be mitigating factors. Under trust law, such arguments are relevant to assessing the severity of the conflict—and MetLife is free, in any benefit case, to present evidence of the mitigating effect. *See infra* at 49–50. But the possibility

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[4] For similar reasons, MetLife is incorrect in asserting that fiduciaries deserve utmost deference because they "have much more extensive experience reviewing the merits of such claims than do federal courts." Pet'r 28. Once, again, this Court rejected the same argument—advocating greater deference for *un*conflicted fiduciaries—in *Firestone*. 489 U.S. at 113–15. It is even less persuasive here. In any event, as the Third Circuit has pointed out, claims adjusters "are not governmental agencies who are frequently granted deferential review because of their acknowledged expertise. [Adjusters] may be laypersons appointed under the plan, sometimes without any ... training preparing them for their responsible position, often without any experience in or understanding of the complex problems arising under ERISA." *Luby v. Teamsters Health, Welfare & Pension Trust Funds*, 944 F.2d 1176, 1183 (3d Cir. 1991); *see also Bruch v. Firestone Tire & Rubber Co.*, 828 F.2d 134, 144 (3d Cir. 1987), *aff'd in part, rev'd in part on other grounds*, 489 U.S. 101 (1989); *Ramsey*, 77 F.3d at 205.

that factors might mitigate the conflict does not justify ignoring the conflict entirely.

2. Adequacy of arbitrary-and-capricious review. MetLife posits that courts need not even consider the dual-role conflict, because "the faulty reasoning offered in an attempt to justify an inappropriate denial of a meritorious claim will inevitably result in a finding that the decision is arbitrary and capricious on judicial review." Pet'r 35–36. There is nothing inevitable about it. Under the arbitrary-and-capricious standard—at least as applied by the lower courts—a court will uphold the fiduciary's decision so long as there is "a *rational connection* between the facts found ... and the choice made"; a court will overturn a plan interpretation only if it "defies *all* common sense." *Dabertin v. HCR Manor Care, Inc.*, 373 F.3d 822, 828 (7th Cir. 2004) (emphasis added). It does not take the genius of a Charles Ponzi for an adjuster bent on denying a meritorious claim to satisfy this standard, especially if the claim presents a close call. If "the outcome in a close case is influenced in part by a desire to control the insurer's or plan sponsor's costs, the fiduciary's claim denial *surely will not disclose that fact.*" PETER J. WIEDENBECK, ERISA IN THE COURTS 194 (2008) (emphasis added) ("WIEDENBECK"). Savvy insurers will cherry pick and accentuate their best facts, while ignoring or diminishing their worst facts with little explanation.

MetLife does not prove otherwise merely by citing a handful of cases—out of millions of claim denials and hundreds of ERISA cases applying the most deferential standard—where the insurer's position happened to fall short of this low threshold.

See Pet'r 35 n.10. These cases prove only what Unum has already taught us: Sometimes insurers are "clumsy villain[s]." Langbein, 101 NW. U. L. REV. at 1321. Evidence that some villains get caught is hardly proof that there are no "subtler operators" who evade detection. *Id.*

Much more informative is the statistic MetLife cites about the outcome of the Unum investigation. Expert regulators concluded that some 200,000 denials were potentially tainted by conflict that either went unchallenged by claimants or uncorrected by reviewing courts. Pet'r 37. Of the denials Unum reviewed, it came to conclude that 40% were improper. *See Unum Group Swings to Profit from Quarterly Loss; Claims Reassessment 'Substantially Completed'*, BEST WIRE (Nov. 1, 2007), *available at* Lexis, News Database. Indeed, the deferential standard of review is what emboldened Unum to cheat: When there are "gray areas," one Unum executive enthused, "ERISA applicability may influence our course of action." Langbein, 101 NW. U. L. REV. at 1321 n.40 (internal quotation marks omitted).

3. Agency oversight. MetLife is correct that "it is the province of state insurance departments" and the Department of Labor "to *oversee and systematically examine* insurance practices, including claims processing." Pet'r 37 (emphasis added). Both the Department of Labor and the National Association of Insurance Commissioners insist that their oversight is no substitute for adequate scrutiny of claims in *individual cases*. *See generally* U.S. Br.; NAIC Br.

As these agencies understand, Congress prescribed complementary roles for *both* regulators

and judges. Congress expected the regulators to provide *systematic* oversight. But Congress vested judges with the equally important responsibility to review *individual claims for benefits due*—like this one—under § 1132(a)(1)(B), and to do so in a way that advances ERISA's goal "to protect contractually defined benefits." *Firestone*, 489 U.S. at 113 (internal quotation marks omitted). When Congress eliminated employees' rights to bring contract actions, Congress was not signaling that employees who have been cheated should feel sufficiently consoled by the possibility that some regulator might some day punish the insurer for a systematic abuse.

4. Contractual intent. Finally, MetLife asserts that diminishing deference for a conflicted trustee would amount to "rewrit[ing] the deferential standard that the plan settlor envisioned when it delegated discretionary authority to the claim fiduciary." Pet'r 28–29.

That may conceivably be true, but, if so, it is because this Court rejected the contract paradigm in *Firestone* when it concluded that trust law controls. 489 U.S. at 109–13; *see Firestone*, U.S. Amicus Brief § I.A (advocating contract paradigm); UP Br. § I.E. The settlor in each of the Restatement illustrations and cases discussed above may be said to have intended to grant the conflicted trustee utmost discretion—and might have explicitly done so—but *trust law* intervenes to raise the standard of scrutiny in the interest of better pro-

tecting the beneficiary.[5] Because this Court imported the trust law principles built into ERISA—including a non-waivable duty of loyalty—to fashion a standard of review, ERISA does the same.

II. A COURT REVIEWING A DUAL-ROLE INSURER'S BENEFIT DENIAL SHOULD START WITH "ESPECIALLY CAREFUL SCRUTINY" AND DIMINISH DEFERENCE AS THE CIRCUMSTANCES WARRANT.

Exactly how a dual-role conflict affects the standard of review has "bedeviled the lower courts." WIEDENBECK, at 192. One reason is that they treat it as a single question. In truth, the inquiry boils down to three questions: (A) What level of deference should a dual-role insurer's decisions enjoy in cases involving a bare conflict? (B) Does the level of deference ever diminish from that baseline, and, if so, under what circumstances? (C) Do the burdens ever shift to the insurer? We address each in turn. For this case, however, the precise contours of the standard do not matter, for the Court of Appeals would have reached the same conclusion under any standard.

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[5] When this Court stated in dicta in *Firestone* that "[n]either general principles of trust law nor a concern for impartial decisionmaking ... forecloses parties from agreeing upon a narrower standard of review," 489 U.S. at 115, it merely recognized that settlors may grant discretionary authority to trustees. *Id.* at 111–13. It did not purport to decide how much deference a conflicted trustee would enjoy.

A. Review of the Decisions of a Dual-Role Insurer Must Begin with "Especially Careful Scrutiny."

1. The most explicit statement in the most current and definitive distillation of trust law describes how courts should account for a bare conflict: Whenever bare "conflict-of-interest situations exist"—i.e., even when there is no additional evidence that the conflict affected the fiduciary's decision—"the conduct of the trustee in the administration of the trust will be subject to *especially careful scrutiny*." THIRD RESTATEMENT § 37, cmt. f(1) (emphasis added).

What does "especially careful scrutiny" mean? In ERISA cases, most courts of appeals, echoing trust law, have held that a conflicted "fiduciary's judgment will ... be scrutinized more closely," which means that "deference will be lessened." *Doe v. Group Hospitalization & Med. Servs.*, 3 F.3d 80, 86–87 (4th Cir. 1993). Some say they are applying "abuse of discretion review, tempered by skepticism," *Abatie v. Alta Health & Life Ins. Co.*, 458 F.3d 955, 959 (9th Cir. 2006) (en banc), while others say they will defer only "to an administrator's reasonable and carefully considered conclusions," *Post*, 501 F.3d at 164.

Lower courts, however, have been struggling with how to apply these standards. *See generally* LAS-ELC Br. § IV. Sometimes, they announce that they are considering the conflict, but then proceed with the analysis as if the conflict did not exist, much as the District Court did in this case. *Id.* Other times, they purport to apply a heightened version of arbitrary-and-capricious review, but in practice scarcely apply any scrutiny at all. *Id.*; *see,*

e.g., *Brigham v. Sun Life of Can.*, 317 F.3d 72, 81–86 (1st Cir. 2003). The lower courts need this Court's guidance not just on the name of the standard, but on how to apply it. *Fought v. Unum Life Ins. Co. of Am.*, 379 F.3d 997, 1004 (10th Cir. 2004) ("Our failure to articulate clearly the requirements of a less deferential arbitrary and capricious standard has left district courts in this circuit without direction and has encouraged litigation."). Failure to do so is like admonishing a foreigner to be especially quiet at the U.S. Open, without telling him whether the frame of reference is a soccer match or a chess match.

Because the standard is stated in comparative terms, the starting point for discerning the meaning of "especially careful scrutiny" must be the standard of review for an unconflicted trustee. An unconflicted trustee's decision "will not be disturbed if *reasonable*." *Firestone*, 489 U.S. at 111 (emphasis added). That is not the same as the arbitrary-and-capricious standard courts apply to expert administrative agencies operating under stricter procedural requirements. *See* Profs. Br. § II.A; *supra* at 38-39. *Reasonableness*, in trust law, requires more than just some rational connection between a shred of evidence and the conclusion. *See, e.g.*, *Copp v. Worcester County Nat'l Bank*, 199 N.E.2d 200, 202 (Mass. 1964).

"[E]specially careful scrutiny," then, means scrutiny must be enhanced above that baseline of review for reasonableness. Because the point of enhanced scrutiny is to enable the reviewing court to satisfy itself that the conflict did not affect the outcome—whether consciously or unconsciously—courts take whatever additional steps are necessary

to achieve that goal. In some trust cases, courts accord a conflicted trustee no deference at all.[6] In most, the courts still defer, just not as much as they would to a conflict-free trustee.[7] Certain practices are readily discernible from the body of case law. *See supra* at 27 n.3 (citing cases); Profs. Br. §§ II.A–B (cataloging cases); *see also Gebelein*, 456 So. 2d at 1239–40; *Halas*, 568 N.E.2d at 175–77. First and foremost, courts applying this standard invariably re-weigh the evidence to ascertain for themselves whether the trustee's position seems out of synch with the range of reasonableness they would expect from an unconflicted trustee. Profs. Br. §§ II.A–B. Beyond that, these cases typically (1) demand complete and careful explanations; (2) cast a skeptical eye on the explanations they do receive; and (3) exhibit little tolerance for analytical flaws or evidentiary gaps. *Id.*

This trust law standard is the approach that best balances ERISA's competing interests as well. On the one hand, it preserves the discretion the plan grants to the insurer, without presuming that their decisions are wrong or tainted. On the other hand, this standard casts the court in the important, and traditional, role of protecting the beneficiary's contractual and statutory rights by ensuring that dual-role insurers act solely in the interests of plan beneficiaries, a fundamental and non-

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[6] *See, e.g., First Nat'l Bank of Beaumont v. Howard*, 229 S.W.2d 781, 785 (Tex. 1950); *Rogers v. Rogers*, 18 N.E. 636, 637–38 (N.Y. 1888); *Armington v. Meyer*, 236 A.2d 450, 456 (R.I. 1967).

[7] *See, e.g., Buchar's Estate*, 74 A. at 238; *Mesler*, 318 So. 2d at 533; *Peabody's Will*, 96 N.Y.S.2d at 561.

waivable requirement of ERISA. 29 U.S.C. § 1104(a)(1)(A). And the standard is not so deferential as to allow—and even encourage—widespread abuse, whether from a "clumsy villain" or from "subtler operators." Langbein, 101 NW. U. L. REV. at 1321.

2. One reason the lower courts have been confused is that many have misinterpreted this Court's direction, in *Firestone*, that a dual-role "conflict must be weighed as a 'facto[r] in determining *whether there is an abuse of discretion*.'" 489 U.S. at 115 (quoting SECOND RESTATEMENT § 187, cmt. d (emphasis added)). Some courts have read this statement—as MetLife does here—to mean that a court must apply an "abuse-of-discretion [*standard of*] *review* ... even when the trustee operates under an actual conflict of interest." Pet'r 43 (emphasis altered); *see Ellis v. Metro. Life Ins. Co.*, 126 F.3d 228, 233 (4th Cir. 1997) ("[I]n no case does the court deviate from the abuse of discretion standard."). This reading confuses an abuse-of-discretion *standard of review* (as that term is often used in administrative law) with a *legal conclusion* that a trustee has abused his discretion (under trust law).

In trust law, the determination that a trustee has "abused his discretion" is the *legal conclusion* a court reaches—a label the court applies—upon overriding the trustee's decision. *See, e.g.*, BOGERT ON TRUSTS § 560; Profs. Br. § II.A. It is a shorthand for an act that justifies "judicial intervention on the ground of abuse." THIRD RESTATEMENT § 87, cmt. c.

That is not the same as declaring that this determination of abuse must always be made using a particular standard of review. And it is certainly

not the same as a conclusion that the decisions of *conflicted* trustees must be adjudged by the same arbitrary-and-capricious standard (borrowed from administrative law) that is routinely applied to *un*-conflicted fiduciaries. The Restatement itself draws the distinction. It explains that "[w]hat *constitutes an abuse of discretion* depends on the terms and purposes of the trust, ... as well as on applicable principles of fiduciary duty." THIRD RESTATEMENT § 87, cmt. b. One of those principles is that, when reviewing the decisions of a conflicted fiduciary, a court can find abuse of discretion upon applying "especially careful scrutiny." *See supra* at 42. Simply put, an arbitrary-and-capricious *standard of review* that applies "especially careful scrutiny" is a contradiction in terms. *See supra* at 38–39 (discussing highly deferential standard). As this Court recently observed, it is questionable "just how deferential the review can be when the judicial eye is peeled for conflict of interest." *Rush*, 536 U.S. at 384 n.15.

B. Deference to a Dual-Role Insurer Should Decline As Scrutiny Exposes Additional Reasons to Suspect That the Conflict May Have Affected the Insurer's Decision.

1. "[E]specially careful scrutiny" is the starting point for a court confronting a bare dual-role conflict. But when scrutiny exposes *additional* reasons to suspect that the conflict may have affected the insurer's decision, deference should diminish accordingly—all the way to *de novo* review when the suggestion of taint is strong. *See generally* LAS-EC Br. § V.

This pattern, too, is evident in countless trust law cases. *See supra* at 27 n.3, 44 nn. 6–7; Profs. Br. § II. Precisely because they discern that pattern in trust law, virtually every circuit agrees that, under ERISA, deference should decrease in proportion to the quantum of evidence that the conflict might have affected the outcome. *See* Kathryn Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U. L. REV. 1083, 1155 (2001) (cataloguing cases). Under this approach, "courts first consider the evidence that the administrator acted from an improper motive and heighten their level of scrutiny appropriately." *Post*, 501 F.3d at 161–62. Thus, deference diminishes as the reviewing court finds further reason "to doubt [the insurer's] fiduciary neutrality," *id.* at 165—when "the process *raises* questions," *id.* at 168, or "suspicion," *id.* at 165. The greater the evidence of taint or impropriety, "'the more objectively reasonable the administrator or fiduciary's decision must be and the more substantial the evidence must be to support it.'" *Stup v. Unum Life Ins. Co. of Am.*, 390 F.3d 301, 307 (4th Cir. 2004) (quoting *Ellis*, 126 F.3d at 233).

At some point the suspicion of a taint can be sufficiently strong that the reviewing court should give no deference to the conflicted insurer's decisions and apply *de novo* review.[8] That is the rule

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[8] *See, e.g., Wright v. R.R. Donnelley & Sons Co. Group Benefits Plan*, 402 F.3d 67, 74 (1st Cir. 2005) ("[T]he court may cede a diminished degree of deference—*or no deference at all*—to the administrator's determinations." (internal quotation marks omitted; emphasis added)); *Van Boxel v. Journal Co. Emp'ees Pension Trust*, 836 F.2d 1048, 1052–53

(footnote continued...)

under trust law, for the only reason a fiduciary enjoys *any* deference is that he is obligated to make decisions wholly in the interests of the beneficiary. *See, e.g.*, *Clement v. Larkey*, 863 S.W.2d 580, 581–82 (Ark. 1993); *Buchar's Estate*, 74 A. at 237. That rule translates into ERISA as well. After all, undivided loyalty is a fundamental and non-waivable *requirement* of ERISA. *See* 29 U.S.C. § 1104(a)(1)(A). When evidence leads a court to harbor serious doubts about it, it makes no sense to accord the fiduciary any deference at all.

2. In determining whether to diminish deference (and how much), courts should be free to evaluate any evidence bearing on the conflict or the fiduciary's behavior. It is impossible here to enumerate all the relevant factors, and this Court need not try. But one of the most important steps the Court can take to guide the lower courts and ensure uniformity is to adopt a basic framework and articulate, with illustrations, the *sorts* of factors that the lower courts should look out for in fixing the degree of deference.

The Third and Ninth Circuits have offered both a useful analytical structure and a helpful, non-exhaustive list of factors that reviewing courts should consider. *See Post*, 501 F.3d at 162–65; *Abatie*, 458 F.3d at 969–71. The factors fall into two basic categories—"procedural" and "structural." *Post*, 501 F.3d at 162.

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(7th Cir. 1987) (for "a serious conflict of interest, the proper deference to give their decisions may be ... zero").

The most common form of evidence that a conflicted fiduciary succumbed to the conflict is evidence about the *process*—"how the administrator treated the particular claimant." *Id.* This category includes various "irregularities" such as: "(1) reversal of position without additional medical evidence; (2) self-serving selectivity in the use and interpretation of physicians' reports; (3) disregarding staff recommendations that benefits be awarded," *id.* at 164–65 (citations omitted); (4) "provid[ing] inconsistent reasons for denial"; (5) "fail[ing] adequately to investigate a claim"; (6) "fail[ing] to credit a claimant's reliable evidence," *Abatie*, 458 F.3d at 968; and (7) denying disability after advocating disability to the SSA, without explaining the difference, *Ladd v. ITT Corp.*, 148 F.3d 753, 755–56 (7th Cir. 1998).

MetLife repeatedly describes this case as presenting the bare conflict, "without more." Pet'r i. But there *is* more—much more. The Court of Appeals found ample evidence of the sorts of procedural irregularities that have routinely raised alarm bells, including items (1), (2), (4), (5), (6), and (7), from the above list. *See infra* at 54–55. The presence of these factors would have justified diminishing deference far below the level of "careful scrutiny," and even all the way to zero, i.e., to *de novo* review (which, as we shall demonstrate, is not what the Court of Appeals did).

The structural component "focuses on the financial incentives created by the way the plan is organized," *Post*, 501 F.3d at 162, on the insurer's track record, and other factors extrinsic to the administrative record. Under this rubric, the Third Circuit has identified dual-role insurers--

particularly those that fund the benefits "on a case-by-case basis," as MetLife does—as especially undeserving of deference. *Id.* at 163. Among the other factors the courts of appeals have identified in this category are: (1) whether the administrator "use[s] an independent body to evaluate claims," *id.*; (2) "whether the insurance contract is fixed for a term of years or changes annually, ... [3] whether the fee paid by the company is modified if there are especially large outlays of capital by the insurer," *Pinto*, 214 F.3d at 392, and (4) whether the insurer has displayed "a parsimonious claims-granting history," *Abatie*, 458 F.3d at 968–69.

Notably, several of these structural factors are the very ones that MetLife and its amici recite in an effort to demonstrate that the conflict is less stark for some dual-role insurers. Pet'r 30–31; BCBS Br. at 12–19; ACLI Br. at 3–6, 13–19. Any insurer that insulates its adjusters from the dual-role conflict in these ways, or that has an impeccable record of consistent plan interpretations, should be free adduce such evidence—which would militate against further diminished deference. *See Abatie*, 458 F.3d at 969.

MetLife has adduced none of this evidence in this case, which leads to the question whether this Court (or any reviewing court) should accept MetLife's invitation to presume their existence—a question we turn to next.

C. The Burden of Proof Does Not Shift, but the Burden of Production Should.

Some courts address the dual-role conflict by shifting the burden of proof to the insurer, requiring the insurer to "negate[]" a presumption of

improper influence "by ameliorating circumstances, such as equally compelling long-term business concerns that militate against improperly denying benefits despite the dual role." *Schatz v. Mut. of Omaha Ins. Co.*, 220 F.3d 944, 947–48 (8th Cir. 2000) (internal quotation marks omitted). There is support in trust law for such an approach. *See, e.g., Clement*, 863 S.W.2d at 581–82. But so long as scrutiny is adequate, it is unnecessary to shift the burden of proof.

That said, it is appropriate to shift the burden of *production* to insurers, as to certain facts. For example, insurers are best situated to present evidence of the sort described immediately above—evidence bearing on their own safeguards. *See Concrete Pipe & Prods. of Cal., Inc. v. Constr. Laborers Pension Trust for S. Cal.*, 508 U.S. 602, 626 (1993) ("It is indeed entirely sensible to burden the party more likely to have information relevant to the facts about [the issue] with the obligation to demonstrate [those] facts ...."). It is virtually costless for an insurer to introduce a stock affidavit attesting to its precautions. Dual-role insurers almost never introduce such evidence—perhaps because they have become complacent in the face of fairly toothless review by courts or, just as likely, because they do not take any such precautions.[9]

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[9] One amicus provides a perfect illustration, arguing that insurance companies "have as much incentive to provide employees with bonuses for claim processing accuracy" as those companies do for claim denials. BCBS Br. 15. The public record suggests otherwise. *See supra* at 17-18. But the point here is that MetLife—or any other insurer—is welcome to proudly present to a reviewing court evidence that it

(footnote continued...)

That is their prerogative. But when the record is silent on the subject—as it is here—the claimant should not be penalized for the evidentiary void.

D. The Judgment Should Be Affirmed, Because the Court of Appeals Would Have Reached the Same Conclusion Under Any Standard of Review.

MetLife did not seek certiorari to review whether the Court of Appeals' analysis of the evidence was "[a] faithful application of the abuse-of-discretion standard," Pet'r 45, or whether its various criticisms of MetLife's process were correct. Yet, MetLife devotes more than a quarter of its argument to urging this Court to scrutinize those fact-bound conclusions about the medical evidence, the consistency of Dr. Patel's opinions, and MetLife's about-face. Pet'r 45–56. MetLife even presents an extended legal argument on a question on which this Court pointedly *denied* certiorari. *Compare* Pet. i (second question presented) *with* Pet'r 48–52. All of this is beyond the scope of this case and this Court's customary role.

When it comes to the Court of Appeals' analysis of MetLife's denial, only one question is properly before this Court: In light of the Court of Appeals' analysis, is it necessary to remand the case to apply the standard this Court articulates?

A remand is unnecessary, because the Court of Appeals left no doubt that it would have reached

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minimizes any conflict by rewarding employees for *granting* claims.

the same result under *any* standard. That is clear both from what the court said about the conflict and from what the court said about MetLife's decision.

As to the conflict, the Court of Appeals said that MetLife's dual-role status was a "facto[r]" to be considered; the conflict was "relevant." P.A. 10a. The court mentioned the factor at the outset, *id.*, but the factor did not come up again throughout the court's lengthy analysis of the various flaws that infected MetLife's denial, P.A. 10a–24a. The court did not mention it again until its conclusion, in half a sentence, intermixed with a grab bag of seven other bases for finding an abuse of discretion. P.A. 25a.

The court contrasted its approach with the District Court's approach (which was simply to quote *Firestone*'s sentence about weighing the conflict, *see* P.A. 34a, without any further "consideration"). P.A. 10a. At no point in it is opinion, however, did the Court of Appeals purport to accord MetLife less deference than it would give to an unconflicted fiduciary. To the contrary, the court said it was applying "the 'arbitrary and capricious' standard," P.A. 9a, a "highly deferential standard," P.A. 24a. As if to punctuate the point, the court defined that standard as MetLife does. *Compare* P.A. 9a, 24a–25a *with* Pet'r 34. In short, the most that can be said is that the court considered the conflict as a factor, but gave the factor "*de minimis* weight," just as MetLife proposes. Pet'r 44.

In keeping with the standard it articulated, the court then held that MetLife's "decision ... can only be described as arbitrary and capricious." P.A. 25a. It was not "the result of a deliberative process."

P.A. 2a; *see* P.A. 25a. Nor was it "based on substantial evidence." P.A. 2a. Of the seven *other* bases the court gave in support of that conclusion, noted below, the court described four as "arbitrary" in and of themselves. P.A. 25a.

Thus, contrary to MetLife's assertion, the court did not apply *de novo* review—in name or in effect. Pet'r 45. The court did not, for example, delve into the intricacies of Ms. Glenn's "ejection fraction," her "defibrillator evaluation," her "capture and sensing thresholds," and so forth—as *de novo* review would demand. J.A. 31. As MetLife acknowledges, even on the most deferential version of abuse-of-discretion review, a court may focus on "procedural irregularities in MetLife's disposition of Glenn's claim." Pet'r 46. That is exactly what the court did. It found the following irregularities:

(1) MetLife failed to offer *any reason* "to discount or disagree with" the SSA's determination, P.A. 15a (internal quotation marks omitted), after "reap[ing] a financial benefit" from taking the opposite litigation position, not a month earlier, P.A. 11a. That about-face, alone, "can be considered *arbitrary and capricious.*" P.A. 13a (emphasis added).

(2) "Even more perplexing" was MetLife's "failure *to give any weight* to Dr. Patel's letters ... , in which he clearly stated that he did not believe Glenn was capable of returning to work, sedentary or otherwise." P.A. 15a (emphasis added); *see* P.A. 18a. By that, the court meant that MetLife "did not indicate whether or not it had considered" these letters, and offered no "reason

for rejecting" them. P.A. 19a.

(3) MetLife "seems to have ... almost randomly selected" snippets of information "from [Dr. Patel's] reports." P.A. 16a.

(4) Similarly, MetLife "credit[ed] the check-off forms" over "Dr. Patel's more detailed reports," but "*offered no explanation* for its resolution of the conflict." P.A. 20a (emphasis added).

(5) Ignoring "evidence that [was] offered after [the] initial denial of benefits" was itself "*arbitrary and capricious.*" P.A. 20a–21a (emphasis added).

(6) "[T]he occupational skills analyst and the independent medical consultant were apparently not provided with full information from Dr. Patel on which to base their conclusions." P.A. 25a; *see* P.A. 18a.

(7) Whatever one might say about the quality of the medical evidence, it is "arbitrary" and "unreasonable" to conclude that a *doctor's* "observations and notations regarding stress" can be completely ignored on the ground that they "do not constitute 'supportive medical documentation.'" P.A. 22a–23a.

As is evident from these excerpts, the Court of Appeals did not "fault[] MetLife for failing to discuss *each piece* of evidence in that file." Pet'r 45 (emphasis added). It faulted MetLife for failing to discuss "critical" evidence. P.A. 20a. It also faulted MetLife for exalting a treating physician's single "aberrational" X mark, P.A. 16a, over a consistent three-year stance that "Never" would Ms.

Glenn "be able to resume work" "*For Any Occupation*," J.A. 70, 81, 99, 110 (emphasis added)—and his subsequent insistence that he "never" intended the X to suggest otherwise, J.A. 42.[10]

In sum, if the confluence of all these flaws led the Court of Appeals to conclude that MetLife's decision "can only be described as arbitrary and capricious," P.A. 25a, there is no chance the court will describe it otherwise, regardless of the precise standards on how a conflict is supposed to be weighed.

CONCLUSION

For these reasons, the judgment of the Court of Appeals should be affirmed.

Respectfully submitted,

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[10] In response, MetLife repeatedly insists that Dr. Patel had concluded more than once "that Glenn could perform sedentary work," Pet'r 47; *see* Pet'r 53, 55, so that his later pleas were nothing but a "conveniently-timed change of heart," Pet'r 48, 54, "reached only after MetLife had decided to terminate Glenn's benefits, Pet'r 54. That is incorrect. *See supra* at 6. There is exactly one form in the entire record in which Dr. Patel responds that Ms. Glenn could do sedentary work. Everywhere else, Dr. Patel indicated that Ms. Glenn would "Never" return to work of any kind. *See supra* at 4-5. Moreover, a month *before* MetLife issued its denial, Dr. Patel reported (consistent with all his other reports and forms) that Ms. Glenn could not "handle any kind of stress well at her work and she would be better off being on disability." J.A. 47. This was no "change of heart," but even if it had been, it preceded MetLife's denial.

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